

CERTIFICATE OF DEATH

17278

17269

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>QA's Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN lb <u>31 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marydel</u> <u>05-2</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>67 Kent-Queen Annes Hospital</u>		d. STREET ADDRESS <u>NONE</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>NMA</u> Last <u>Bezerics</u>		4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>JULIA THOMAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-40-7267</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Chestertown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>332X</u> IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia -</u> DUE TO (b) <u>Cerebral thrombosis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>31 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-27</u> , 19 <u>66</u> , to <u>12-28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-28</u> , 19 <u>66</u> , and that death occurred at <u>7:10 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Robt. Farr</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robt. Farr</u>		22d. ADDRESS <u>Chestertown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-31-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lanpherille</u>	23d. LOCATION (City or Town) (County) (State) <u>Lanpherille Md.</u>
24. FUNERAL DIRECTOR <u>J.E. Boulaie Greensboro, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

13508

UNITED STATES OF AMERICA

13518



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17279				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				17270	
1. PLACE OF DEATH a. COUNTY <b>Kent County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton, Maryland</b> c. LENGTH OF STAY in 1b <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton, Maryland</b> d. STREET ADDRESS <b>141</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Norman Cooper</b>					4. DATE OF DEATH Month Day Year <b>December 5 1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1874</b>		9. AGE (in years last birthday) yrs. Months Days <b>92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milk Plant Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Milk Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Kent County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Earle Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Ivens</b>				Address <b>Georgetown, Delaware</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-9006</b>		17. INFORMANT <b>Margarett Henderson</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO <b>Found dead in his trailer.</b> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Robert W. Farr</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>12/6/66</b>	
EXAMINER'S NAME (Type) <b>Robert W. Farr, M.D.</b>				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-7-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Maryland</b>			
24. FUNERAL DIRECTOR <b>J. Carl Cooper</b>				ADDRESS <b>Chestertown MD</b>		25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

13250

13250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

State of New York  
County of New York  
City of New York  
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that on the 12th day of December, 1956, at New York City, New York, I examined the body of  
Name of Deceased  
and found that the cause of death was  
Disease or Injury  
and that the death was due to  
Natural Causes / Accident / Suicide / Homicide / Undetermined  
I further certify that the death was not due to any of the causes specified in the laws of this State relating to the reporting of deaths.

Attest my hand and the seal of my office this 12th day of December, 1956.  
Signature of Medical Examiner  
Seal of Medical Examiner  
I, the undersigned, a duly qualified Medical Examiner, do hereby certify that on the 12th day of December, 1956, at New York City, New York, I examined the body of  
Name of Deceased  
and found that the cause of death was  
Disease or Injury  
and that the death was due to  
Natural Causes / Accident / Suicide / Homicide / Undetermined  
I further certify that the death was not due to any of the causes specified in the laws of this State relating to the reporting of deaths.

12/12/56  
Robert W. [Name]  
12-1-1956  
Chester [Name]  
12-1-1956  
Chester [Name]  
12-1-1956  
Chester [Name]

CERTIFICATE OF DEATH

17280

17271

1. PLACE OF DEATH a. COUNTY <b>KENT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>EMORY</b> Middle <b>LISTER</b> Last <b>CROUCH</b>		4. DATE OF DEATH <b>DECEMBER 24 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARried <input type="checkbox"/> NEVER MARried <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 9 - 1893</b>
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EMORY CROUCH</b>		14. MOTHER'S MAIDEN NAME <b>MARY NEAL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>219-07-6825</b>	
17. INFORMANT <b>THOS. LEGG - ROCK HALL, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis &amp; infarct</b> (c) <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> 19 <b>65</b> to <b>Dec 24</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 24</b> 19 <b>66</b> , and that death occurred at <b>3P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert C. Kutsch</b> M.D.		22b. DATE SIGNED <b>12/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert C. Kutsch</b>		22d. ADDRESS <b>Rock Hall Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Dec 27</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>	23d. LOCATION (City, town or county) (State) <b>Rock Hall MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		25. REC'D BY REGISTRAR <b>JAN 5 1967</b>	
ADDRESS <b>Church Hill, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

27551

07351



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17281

17272

1. PLACE OF DEATH a. COUNTY <b>KENT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCK HALL</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>FRANK</b> First <b>DLUGOBORSKI</b> Middle <b>Dec.</b> Last 4. DATE OF DEATH <b>Dec. 2 1966</b> Month <b>2</b> Day <b>19</b> Year <b>66</b>		5. SEX <b>MALE</b> 6. COLOR OF RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Dec. 3-1880</b> 9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>POLAND</b> 11. BIRTHPLACE (County & State, or foreign country) <b>USA</b> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>UNKNOWN</b> 14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <b>217-36-1449</b> 17. INFORMANT <b>BENNIE DLUGOBORSKI</b> Address <b>Rock Hall Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 443X DUE TO <b>Hypertension, myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>arterio sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> , 19 <b>60</b> , to <b>Dec 2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 2</b> , 19 <b>66</b> , and that death occurred at <b>4A</b> M, from the causes and on the date stated above.				
22a. SIGNATURE <b>Norbert C. Nitsch</b>		22b. DATE SIGNED <b>12/2/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>NORBERT C. NITSCH</b>		22d. ADDRESS <b>ROCK HALL MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec. 6</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE MD.</b>		
24. FUNERAL DIRECTOR <b>Edgard Lane</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1966</b> 25b. REGISTRAR'S SIGNATURE <b>youanles j...</b>		

4259

2851



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17282 CERTIFICATE OF DEATH 17273

1. PLACE OF DEATH a. COUNTY Kent (10 years) MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton (5 yrs)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) at home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) George Leonard Felter		4. DATE OF DEATH Dec. 3, 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1886
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Lumber & Millworks		11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Felter	
14. MOTHER'S MAIDEN NAME ? Hartzler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 172 22 8786		17. INFORMANT Margaretta Orem Felter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis - a few minutes 420.1 DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 12/3, 1966, that (I) (we) last saw the deceased alive on 12-3 1966, and that death occurred at 8:30 M. from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Farr		22b. DATE SIGNED 12/3/66	
22c. PHYSICIAN'S NAME (Type) Robert W. Farr		22d. ADDRESS Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/66	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR DATE DEC 6 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



17283

## CERTIFICATE OF DEATH

17274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>			c. LENGTH OF STAY IN lb <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> <u>14.1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent &amp; Queen Anne's Hospital, Inc.</u>				d. STREET ADDRESS <u>Rt. #3 Langford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gurtha Emily Hess</u>				4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/3/86</u>	
9. AGE (In years last birthday) yrs. <u>80</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Caroline Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Louis Price VanZant</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Emily Jarvis</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>220-30-6524</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>581.0</u> IMMEDIATE CAUSE (a) <u>Complications of prolonged varicella</u> DUE TO (b) <u>Unborn of live</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>3 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> , 19 <u>66</u> , to <u>12-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>66</u> , and that death occurred at <u>5:47 p</u> M, from causes on and on the date stated above.							
22a. SIGNATURE <u>A.C. Dick</u>				22b. ADDRESS <u>Chestertown, Md.</u>		22c. DATE SIGNED <u>12-13-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Jarrettsville, Md.</u>	
24. FUNERAL DIRECTOR <u>Edward Fellows,</u>				ADDRESS <u>Millington, Md. 21651</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

13521

13523

Prof. J. H. ...  
... of ...

Hypertension

A.C. Dick  
Charleston, W.Va.  
12-13  
12-13

1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the physician should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

<div style="display: flex; justify-content: space-between;"> <div> <p>17284</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> </div> <div> <p>17275</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			c. LENGTH OF STAY IN 1b <b>one hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Massey</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent and Queen Anne Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alvin</b> First <b>Joseph</b> Middle <b>Johnson</b> Last					4. DATE OF DEATH <b>Dec.</b> Month <b>6</b> Day <b>1966</b> Year				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/16/66</b>		9. AGE (In years last birthday) <b>xx years</b> yrs. <b>3</b> Months <b>20</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joe McGinnis</b>					14. MOTHER'S MAIDEN NAME <b>Doris Lee Johnson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>R.D.</b> <b>Mrs. Dorothy Johnson, Millington, Md. 21651</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown, possible upper respiratory infection SD II</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Appeared well until AM 12/6/66. Wouldn't eat breakfast. At 8:00AM while getting bath suddenly developed respiratory difficulty.</b> DUE TO (b) <b>short</b> DUE TO (c) <b>ed respiratory difficulty.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>short</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>475X</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>respiratory infection</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Robert W. Farr</b>					22. DATE SIGNED <b>12/6/66</b>				
EXAMINER'S NAME (Type) <b>Robert W. Farr, M.D.</b>					Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Busic Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Barclay, Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Edward Fellows. Millington, Md. 21651</b>					25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1999

1102-710

7928

រំលឹកស្រី.

22/05/82

•

Norman Lee Johnson

SECRET

Robert M. La Follette

1996



17285

## CERTIFICATE OF DEATH

17276

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
c. LENGTH OF STAY IN lb <u>21 days</u>		d. STREET ADDRESS <u>125 Washington Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent &amp; Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Clawson Jones</u>		4. DATE OF DEATH <u>12 16 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-21-1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Queen Anne's Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Walton Jones</u>		14. MOTHER'S MAIDEN NAME <u>Anna Rebecca Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-3780</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma (carcinoma of colon)</u> DUE TO (b) <u>Adenocarcinoma of rectosigmoid</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-25</u> , 19 <u>66</u> , to <u>12-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-15</u> , 19 <u>66</u> , and that death occurred at <u>1:45</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>A.C. Dick</u>		22b. DATE SIGNED <u>12-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		22d. ADDRESS <u>Chestertown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Sudlersville, Md.</u>	
24. FUNERAL DIRECTOR <u>J. Willis Wells</u>		25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>	
ADDRESS <u>Chestertown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

435

1536

*Reinhold Messner*

2535

21.5.02

17286

## CERTIFICATE OF DEATH

17277

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>			c. LENGTH OF STAY IN lb <b>25 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENNEDYVILLE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>KENT-QUEEN ANNES HOSPITAL</b>				d. STREET ADDRESS <b>14.1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RACHEL ELIZABETH LUSBY</b>				4. DATE OF DEATH Month Day Year <b>12 24 1966</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/10/91</b>		9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>KENT CO. MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>RICHARD ? BRYAN DEC.</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE ? DEPUTY DEC</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSPITAL RECORDS CHESTERTOWN, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>153.1 Carcinoma of colon at splenic flexure</b> IMMEDIATE CAUSE (a) <b>postoperative</b> DUE TO (b) <b>22 days</b> DUE TO (c) <b>22 days</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11 / 29, 1966</b> to <b>12/24, 1966</b> that (I) (we) last saw the deceased alive on <b>12/24, 1966</b> , and that death occurred at <b>10:45 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>R. H. Farr</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robt. Farr</b>				22d. ADDRESS <b>Chestertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-27-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHESTER CEMT</b>		23d. LOCATION (City or Town) (County) (State) <b>CHESTERTOWN KENT MD</b>	
24. FUNERAL DIRECTOR <b>Victor M. Kennedy</b>				ADDRESS <b>STILL POND, MD</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15831

CERTIFICATE OF DEATH

15831

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death	
John Doe		45		Male		White		1930-01-01		1975-03-15		New York City		Heart Disease	
Occupation		Education		Marital Status		Religion		Social Security Number		Burial Place		Burial Date		Burial Name	
Teacher		High School		Married		Catholic		123-45-6789		St. Mary's		1975-03-20		John Doe	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer		Signature of Cemetery		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

15831-15832 CHESTER COUNTY CHESTERMAN NEXT  
15831-15832 CHESTERMAN NEXT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>14 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>At Home (Quaker Neck Sec.)</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>14-1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Elston</b> Middle <b>PEARCE</b> Last <b>PEARCE</b>					4. DATE OF DEATH <b>Dec. 11, 1966</b> Month <b>Dec.</b> Day <b>11</b> Year <b>19</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 27, 1886</b>		9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS: Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retire Executive (Lumber Industry)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Industry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Montclair, N. Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elijah Pearce</b>					14. MOTHER'S MAIDEN NAME <b>M Phebe Sigler</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>401 12 0695</b>		17. INFORMANT <b>L. Elston Pearce</b> Address <b>Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Bronchopneumonia</b> DUE TO (b) <b>A-S. Cardio-Vascular Disease</b> DUE TO (c) <b>Chronic Cerebral Insufficiency &amp; Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-8</b> , 19 <b>66</b> , to <b>12-11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-11</b> , 19 <b>66</b> , and that death occurred at <b>11:15</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Arthur T. Keefe</b>					22b. DATE SIGNED <b>12/12/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Arthur T. Keefe</b>		
22d. ADDRESS <b>Chestertown, Md. 21620</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hawthorne, New York</b>		
24. FUNERAL DIRECTOR <b>J. Wilbur Wells</b>					25a. REC'D BY REGISTRAR <b>DEC 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1383

RESIDUAL OF DEATH

1383

1383

1383

1383

1383

(1383)

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383

1383



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
17288					17279				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Kent</b>					a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown (Lifetime)</b>					b. COUNTY <b>Kent</b>				
c. LENGTH OF STAY IN 1b <b>(Lifetime)</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne Hospital (2days)</b>					d. STREET ADDRESS <b>RFD # 2</b>				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
<b>Edward Lambert Plummer</b>						<b>Dec. 7, 1966</b>		<b>19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/3/1888</b>		9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William B. Plummer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Usilton</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>217 05 7578</b>		17. INFORMANT <b>Mrs. Dorothy Plummer</b>			
						Address <b>RFD # 2</b> <b>Chestertown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pulmonary edema</b> DUE TO (c) <b>Bronchopneumonia Bilat</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A-S-C-U-D</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-5</b> , 19 <b>66</b> , to <b>12-7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-7</b> , 19 <b>66</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Harry Paul Ross</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-7-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Harry Paul Ross</b>				22d. ADDRESS <b>Chestertown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Md.</b>			
24. FUNERAL DIRECTOR <b>J. Wells Wells</b>				ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

2685

15532

X

17289

CERTIFICATE OF DEATH

17280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent-Queen Anne's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry George Sewell</b>		4. DATE OF DEATH <b>12 23 19 66</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-1898</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Watchman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co. Maryland</b>	
13. FATHER'S NAME <b>George Basil Sewell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes unknown</b>		16. SOCIAL SECURITY NO. <b>154-12-1231</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> DUE TO (b) <b>CORONARY ARTERIAL DISEASE</b> DUE TO (c) <b>ARTERIO-SCLEROSIS -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS SEVERAL YEARS SEVERAL YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Broncho pneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Hour o.m. 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>George A. Ortega, M.D.</b>		22b. DATE SIGNED <b>12/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>George A. Ortega</b>		22d. ADDRESS <b>Chestertown Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 24/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Whisley Chapel Am</b>		23d. LOCATION (City or Town) (County) (State) <b>Rock Hall Kent Md.</b>	
24. FUNERAL DIRECTOR <b>Marvin V. Williams</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>	
ADDRESS <b>Chestertown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

9357

ISSN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
17290					CERTIFICATE OF DEATH					17281				
1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN lb <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne's Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>141 212 Chestertown</b> d. STREET ADDRESS <b>212 Washington Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Skirven</b> Last <b>Startt</b>					4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>19 66</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/29/1902</b>		9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. School Principal</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>					
13. FATHER'S NAME <b>H Stockton Startt</b>					14. MOTHER'S MAIDEN NAME <b>Ada Skirven</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 16 6932</b>		17. INFORMANT <b>Hospital Records</b> Address <b>Chestertown, Maryland</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 HEART FAILURE</b> DUE TO (b) <b>Ruptured Heart</b> DUE TO (c) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <b>FEW MINUTE</b> <b>7 days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> , 19 <b>66</b> , to <b>12/22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/22</b> , 19 <b>66</b> , and that death occurred at <b>10 AM</b> , from causes and on the date stated above.														
22a. SIGNATURE <b>George A. Oteiza</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/22/66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Dr. Oteiza</b>					22d. ADDRESS <b>Chestertown, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b>								
24. FUNERAL DIRECTOR <b>J. Willis Wells</b> ADDRESS <b>Chester town, Md.</b>					25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

9251

Let's School Yourself

Journal of Management Education 32(10)

1957-1958

18521



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
17291 CERTIFICATE OF DEATH 17282

1. PLACE OF DEATH a. COUNTY <b>Kent</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kent &amp; Queen Anne Hospital D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>1708 Park Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>W.</b> Last <b>Strong</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>3,</b> Year <b>1966</b>						
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/1899</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>67</b>	IF UNDER 24 HRS. Days <b>67</b>	Hours <b>67</b>	Min. <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Contractor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Edgar H. Strong</b>				14. MOTHER'S MAIDEN NAME <b>Rose B. Crouch</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>416 01 8549</b>		17. INFORMANT <b>Julia Strong</b> <b>1708 Park Ave. Baltimore, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.0</b> <b>Cardiac arrest</b> DUE TO (b) <b>Coronary artery disease</b> DUE TO (c) <b>(Had history of Stokes-Adams attacks)</b> INTERVAL BETWEEN ONSET AND DEATH <b>Short</b> <b>Several years</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12-3, 1966</b> , to <b>12/3, 1966</b> , that (I) (we) last saw the deceased alive on <b>12-3, 1966</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above.								
22a. SIGNATURE <b>Robert W. Farr</b>				22b. DATE SIGNED <b>12/4/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>		
22d. ADDRESS <b>Chestertown, M D.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cem.</b>		23d. LOCATION (City, town or county) (State) <b>near Chestertown, Md.</b>		
24. FUNERAL DIRECTOR <b>Charles Wells</b>		24a. ADDRESS <b>Chestertown, Md.</b>		24b. REC'D BY REGISTRAR <b>DEC 3 1966</b>		24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

50561

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                  |  |  |  |  |  |   |  |   |  |
|--|--|------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                  |  |  |  |  |  |   |  |   |  |
| 17292  |  |                  |  |  |  | 17283  |  |   |  |   |  |
| 1. PLACE OF DEATH  |  |                  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)          |  |   |  |   |  |
| a. COUNTY <u>Kent County, Maryland</u> MARYLAND  |  |                  |  |  |  | a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>   |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |  |                  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)               |  |   |  |   |  |
| <u>R.F.D. Chestertown, Md.</u>   |  |                  |  |  |  | <u>R.F.D. Chestertown, Maryland</u>  |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |                  |  |  |  | d. STREET ADDRESS  |  |   |  |   |  |
| <u>At Home</u>   |  |                  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)  |  |                  |  |  |  | 4. DATE OF DEATH   |  |   |  |   |  |
| First <u>Sarah</u> Middle <u>Maria</u> Last <u>Taylor</u>  |  |                  |  |  |  | Month <u>12</u> Day <u>27</u> Year <u>1966</u>   |  |   |  |   |  |
| 5. SEX   |  | 6. COLOR OR RACE |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday) <u>87</u> yrs.                              |  | IF UNDER 1 YEAR Months Days   |  |
| <u>Female</u>  |  | <u>Colored</u>   |  |  |  | <u>3/28/1879</u>   |  |   |  | IF UNDER 24 HRS. Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| <u>Labor</u>   |  |                  |  | <u>Various</u>   |  | <u>Kent County, Maryland</u>   |  |   |  | <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME  |  |                  |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |   |  |   |  |
| <u>Henry Wilson</u>  |  |                  |  |  |  | <u>Martha Caulk</u>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |                  |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address <u>R.F.D.#</u>  |  |   |  |
| <u>No</u>  |  |                  |  |  |  | <u>216-56-0845</u>   |  | <u>Miss. Dorothy Taylor Chestertown, Md.</u>                                |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |  |                  |  |  |  |  |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blood circulatory failure</u>  |  |                  |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>One day</u>                             |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary insufficiency</u>  |  |                  |  |  |  |  |  |   |  | <u>4-5 years</u>  |  |
| DUE TO (c) <u>Sclerosis of blood vessels</u>   |  |                  |  |  |  |  |  |   |  | <u>10 years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                  |  |  |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                  |  |  |  |  |  |   |  |   |  |
| MEDICAL CERTIFICATION  |  |                  |  |  |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  |                  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August 16, 1965</u> to <u>December 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>December 27, 1966</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above. |  |                  |  |  |  |  |  |   |  |   |  |
| 22a. SIGNATURE <u>Geza Koralewski</u>  |  |                  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/>              |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED <u>1/3/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Geza Koralewski M.D.</u>   |  |                  |  |  |  | 22d. ADDRESS <u>Millington, Maryland</u>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                  |  | 23b. DATE THEREOF <u>1/1/1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Joshua Chaple Cem.</u>                                   |  |   |  | 23d. LOCATION (City, town or county) (State) <u>R.F.D. Chestertown, Md.</u> |  |
| 24. FUNERAL DIRECTOR <u>Kenneth W. Wally</u> ADDRESS <u>Chestertown, Md.</u>   |  |                  |  |  |  | 25a. REC'D BY REGISTRAR <u>JAN 9 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                             |  |   |  |

1732

CERTIFICATE OF DEATH

1732

1871 87

1871

*James W. Smith*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 17293   |  |   |   |   | 17284  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Kent MARYLAND  |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE Md. b. COUNTY Kent                 |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Millington  |  |   | c. LENGTH OF STAY IN 1b                                 |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Rural Millington 14.1                            |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Private Home  |  |   |   |   | d. STREET ADDRESS  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First MIDDLE Last<br>RAY ALBERT THOMAS   |  |   | 4. DATE OF DEATH<br>Month Day Year<br>December 11, 1966 |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |   |  |   |  |
| 5. SEX<br>Male  |  | 6. COLOR OR RACE<br>Colored   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>February 20, 1881                                     |  | 9. AGE (In years last birthday) 85<br>IF UNDER 1 YEAR<br>Months Days Hours Min.                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Farm Labor   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Farming.           |   | 11. BIRTHPLACE (County & State, or foreign country)<br>Md.   |   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>John Thomas.   |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Johnson.   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No.  |  |   | 16. SOCIAL SECURITY NO.<br>212-32-2126                  |   | 17. INFORMANT<br>Mrs. Violetta Duckery, Millington, Md. 21651  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Decompensation of the heart</u><br>DUE TO (b) <u>Coronary sclerosis</u><br>DUE TO (c) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>3 days - 9 years - 10 years                                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                      |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 25</u> , 19 <u>66</u> , to <u>Dec. 11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 10</u> , 19 <u>66</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.                                       |  |   |   |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>Geza Koralewski</u>  |  |   |   |   | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br>12.13.66           |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br>Geza Koralewski. M.D.   |  |   |   |   | 22d. ADDRESS<br>Millington, Md. 21651  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE THEREOF<br>Dec. 15, 1966  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Davis Hill Cemetery   |  | 23d. LOCATION (City, town or county) (State)<br>Galena Rural Kent Co; Md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>Edward Fellows,   |  |   |   |   | ADDRESS<br>Millington, Md. 21651   |   | 25a. REC'D BY REGISTRAR<br>DEC 16 1966 |   |  |
|   |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |  |   |  |



1000  
1000

11 1955  
February 20, 1955

11 1955  
February 20, 1955

11 1955  
February 20, 1955

11 1955  
February 20, 1955

11 1955  
February 20, 1955

11 1955  
February 20, 1955

11 1955  
February 20, 1955

11 1955  
February 20, 1955